SOUTHERN HEALTH SERVICES, INC.
A Coventry Health Care Plan

Enrollment/Change Form

COVENTRY
Health and Life Insurance Company

A. EMPLOYER INFORMATION (To be completed by Employer)

Group No.	Group Name	Effective Date	Employer's Signature	Date

B. SUBSCRIBER INFORMATION (To Be Completed by Employee)

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY COVERED INDIVIDUALS:

Southern Health Services, Inc. VirginiaCare (PCP Required)
- ❑ HMO (Deductible ❑YES $________ or ❑ NO)
- ❑ POS (Deductible ❑YES $________ or ❑ NO)

Southern Health Services, Inc. VirginiaValue (PCP Required)
- ❑ HMO (Deductible ❑YES $________ or ❑ NO)
- ❑ POS (Deductible ❑YES $________ or ❑ NO)

Coventry Health and Life Insurance Company (No PCP Required)
- ❑ VirginiaValue PPO (Deductible ❑YES $________ or ❑ NO) ❑ Satellite HDHP ❑YES or ❑ NO
- ❑ VirginiaCare PPO

PLEASE MAKE THE FOLLOWING CHANGES: **Please include supporting documention for the change.**

ENROLL
- ❑ Open Enrollment
- ❑ New Hire (date of hire) ____________________
- ❑ COBRA (date of eligibility) ____________________
- ❑ Qualifying Event (description/date) ____________________

CHANGE
- ❑ Add Individual (reason for addition) ____________________
- ❑ Delete Individual (reason for deletion) ____________________
- ❑ Name Change (previous name) ____________________
- ❑ Physician Change
- ❑ Address Change

TERMINATE COVERAGE
- ❑ Cancel Coverage (reason) ____________________
- ❑ Last Date of Employment ____________________

EMPLOYMENT STATUS
Please check one:
- ❑ ACTIVE
- Hire Date ____________
- ❑ RETIRED
- ❑ TERMINATED
- Dept. ____________

MARITAL STATUS
Please check one:
- ❑ SINGLE/WIDOWED
- ❑ MARRIED
- ❑ DIVORCED

LAST NAME	FIRST NAME	MI	M/F	BIRTHDATE	SOCIAL SECURITY NO.

ADDRESS	PRIMARY CARE PHYSICIAN	CURRENT PATIENT (Y or N) PCP ID#

CITY	STATE	ZIP	WORK/DAY PHONE	HOME PHONE	

C. OTHER INSURANCE

Do you or your covered individuals have other coverage? No ❑ If Yes, complete the following:

List all individuals covered by the subscriber with medical health insurance in addition to Southern Health Services, Inc. (Southern Health) or Coventry Health and Life Insurance Company (CHLIC).

POLICY HOLDER	BIRTHDATE	EMPLOYER	INSURANCE COMPANY

LIST INDIVIDUALS COVERED	EFFECTIVE DATE	CONTRACT NO./GROUP NO.

Do you or your covered individuals have Medicare Coverage? ❑ Yes ❑ No If Yes, please complete the following:

NAME	MEDICARE ID NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
NAME	MEDICARE ID NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

PLEASE COMPLETE REVERSE SIDE.

D. INDIVIDUAL MEMBERS TO BE COVERED OR DELETED

ENROLL OR DELETE	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTHDATE	OUT OF AREA STUDENT	SOCIAL SECURITY #	PRIMARY CARE PHYSICIAN	PCP ID#	CURRENT PATIENT?
E D		M/F		/ /		- -			
E D		M/F		/ /	Y/N	- -			
E D		M/F		/ /	Y/N	- -			
E D		M/F		/ /	Y/N	- -			
E D		M/F		/ /	Y/N	- -			
E D		M/F		/ /	Y/N	- -			

E. CONDITIONS OF ENROLLMENT

I hereby apply for membership or request a change in membership in this Southern Health Services, Inc. (Southern Health)/Coventry Health and Life Insurance Company (CHLIC) Plan. I understand that my enrollment and benefits are in accordance with those described in the applicable Evidence of Coverage or Certificate of Insurance, and Group Agreement or Group Policy. I authorize 1) all health providers and insurers to furnish Southern Health/CHLIC, and 2) all health providers and Southern Health/CHLIC to furnish all insurers and health providers records concerning me or any of my covered individuals for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I certifiy that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Southern Health/CHLIC. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for thirty months from the date the authorization is signed.

I HAVE READ AND AGREE TO THE CONDITIONS OF ENROLLMENT. If enrolling in an HMO plan, I acknowledge a POS plan has been offered. ❑ YES ❑ NO

Employee Signature	**Date**